

N323 Care Plan

Lakeview College of Nursing

Name: *Kati Davis*

4.19.2022

Demographics (3 points)

Date of Admission 4/16/2022	Patient Initials J.H	Age 20	Gender Female
Race/Ethnicity Asian	Occupation Student	Marital Status Single – Never married	Allergies NKA
Code Status FULL	Observation Status Q 15 Minute monitoring	Height 5' 7"	Weight 150lbs

Medical History (5 Points)

Past Medical History: *The patient denies any active medical conditions.*

Significant Psychiatric History: *The patient has had no previous inpatient psychiatric admissions. The patient is under the care of Dr. Laprise in McKinley Care Clinic since October 2021, and has been on several antidepressants, including, bupropion, mirtazapine, and escitalopram since October of 2021. Upon interviewing, the patient admits she has bipolar disorder and admits to having a hard time dealing with relationships and especially feelings of abandonment. Her parents divorced when she was 5 years old, and she rarely saw her father. She struggles with feelings of neglect and loneliness.*

Family History: *Denies family history of substance and alcohol abuse. She believes her mother could have BPD, but this is undiagnosed as seeking mental health treatment in China is uncommon.*

Social History (tobacco/alcohol/drugs): *The patient smokes cigarettes and uses a vape. She has done this for the past year (since early 2021.) If she has a stressful day, she will smoke 2 cigarettes or smoke on her vape throughout the day. Denies use of alcohol and illicit drugs.*

Living Situation: *The patient lives alone in an apartment complex.*

Strengths: *The patient is responsible as she has always cared for her younger brother (10yo) and handled financial details for her mother because she does not speak English. The patient states, “I care for people.” The patient naturally has a caretaker role.*

Support System: *Her good friend, Sherry, is her support system.*

Admission Assessment

Chief Complaint (2 points): *Very sleepy after taking 15 antidepressants intentionally.*

Contributing Factors (10 points):

Factors that lead to admission: *The client was admitted from the Carle ER. She presented to Carle ER ON 4/15/22 after a suicide gesture. The patient reported she took a “handful” of about 15 tablets of mirtazapine 15mg last evening (4/15). The client had a breakup with her boyfriend and took the pills somewhat on impulse to “see what would happen.” The patient reports that she and her boyfriend have been having relationship difficulty since Spring break ended and she has been very emotional and sad. She admitted to me during the interview that she knew she would not die with the dose she took she just wanted to get her boyfriend’s attention.*

History of suicide attempts: *None; she does not classify this episode as a suicide attempt as she was aware that the dosage she took would not kill her.*

Primary Diagnosis on Admission (2 points): *Bipolar affective disorder, current episode depressed*

Psychosocial Assessment (30 points)

History of Trauma				
<p>Lifetime experience: Parent’s divorce when she was 5 years old. Her childhood home was chaotic – “not peaceful.” The patient’s mother would get angry, and she would outsource and take this anger out on everyone in the house. “My mom may love me, but she does not know how to love me.”</p> <p>Witness of trauma/abuse: After her stepfather had an affair, her mother would continuously talk hateful to him. She would yell, curse, and blame him for her every emotion.</p>				
	Current	Past (what age)	Secondary Trauma (response that comes from caring for another person with trauma)	Describe
Physical Abuse	No	N/A	N/A	N/A
Sexual Abuse	No	N/A	N/A	N/A
Emotional Abuse	No	“Has happened on and off since early childhood.”	N/A	Mother would speak very harshly. She “lacks love and compassion.” She would never take accountability and always place blame on everyone else. When the patient’s stepfather had an affair, the mother would continuously be hateful towards him and say things to make the patient hate him.
Neglect	No	Earlier in childhood	N/A	Neglected by her boyfriend

				<p><i>because he is not responsive when she expresses that she is not ok.</i></p> <p><i>Neglected by her mother because she has always lacked love but expressed the love and attention she never received to her younger brother.</i></p> <p><i>Neglected by her biological father since her parent's divorce when she was 5yo.</i></p>
Exploitation	No	N/A	N/A	N/A
Crime	No	N/A	N/A	N/A
Military	No	N/A	N/A	N/A
Natural Disaster	No	N/A	N/A	N/A
Loss	No	N/A	N/A	N/A
Other	No	N/A	N/A	N/A
Presenting Problems				
Problematic Areas	Presenting?		Describe (frequency, intensity, duration, occurrence)	
Depressed or sad mood	Yes	No	<p><i>The patient states her ER experience was very bad. The ER staff lacked emotion. She was scared at the ER, and she is scared and sad for what is to come.</i></p>	
Loss of energy or interest in activities/school	Yes	No	<p><i>The patient admits she pulls two all-nighters a week to complete homework. She is lacking sleep</i></p>	

			<i>and ended up losing motive. The patient dropped a class because of this struggle.</i>
Deterioration in hygiene and/or grooming	Yes	No	N/A
Social withdrawal or isolation	Yes	No	<i>The patient states she has hung out with only one friend within the last two weeks.</i>
Difficulties with home, school, work, relationships, or responsibilities	Yes	No	<i>The patient is experiencing lack of motivation to complete courses or schoolwork. The patient is having trouble in relationships after her boyfriend expressed that he needed more space and boundaries. She feels she is being neglected and unheard.</i>
Sleeping Patterns	Presenting?		Describe (frequency, intensity, duration, occurrence)
Change in numbers of hours/night	Yes	No	<i>The patient believes she is sleeping more because of the medications she is on. She is sleeping around 12 hours a night.</i>
Difficulty falling asleep	Yes	No	<i>She has trouble falling asleep; she is taking a melatonin at night before bed this is helping.</i>
Frequently awakening during night	Yes	No	N/A
Early morning awakenings	Yes	No	N/A
Nightmares/dreams	Yes	No	<i>The patient is having extremely vivid dreams about reality. For example, she dreamed about giving her boyfriend back all his things that are in her apartment.</i>
Other	Yes	No	
Eating Habits	Presenting?		Describe (frequency, intensity, duration, occurrence)
Changes in eating habits: overeating/loss of appetite	Yes	No	<i>The patient explains she is overeating. She considers this “stress eating.”</i>
Binge eating and/or	Yes	No	<i>The patient admits she is always</i>

purging			<i>seeking for food. Food brings her comfort.</i>
Unexplained weight loss?	Yes	No	N/A
Amount of weight change:			
Use of laxatives or excessive exercise	Yes	No	N/A
Anxiety Symptoms	Presenting?		Describe (frequency, intensity, duration, occurrence)
Anxiety behaviors (pacing, tremors, etc.)	Yes	No	<i>The patient states she has tremors and an elevated HR in episodes of anxiety.</i>
Panic attacks	Yes	No	<i>The patient experienced a panic attack while at the ER because she felt she was not being cared for with compassion, but more so being treated like she “was crazy.”</i>
Obsessive/compulsive thoughts	Yes	No	N/A
Obsessive/compulsive behaviors	Yes	No	N/A
Impact on daily living or avoidance of situations/objects due to levels of anxiety	Yes	No	<i>Patient stops doing homework and quizzes. She has started to even skip labs.</i>
Rating Scale			
How would you rate your depression on a scale of 1-10?		8	
How would you rate your anxiety on a scale of 1-10?		8	
Current Stressors of Areas of Life Affected by Presenting Problem (work, school, family, legal, social, financial)			
Problematic Area	Presenting?		Describe (frequency, intensity, duration, occurrence)
Work	Yes	No	N/A
School	Yes	No	<i>The patient constantly worries about getting poor grades but is not changing her behavior to</i>

			<i>prevent this. She is constantly thinking about how her GPA will affect getting into grad school. This is a constant worry that affects her mood and these bleeds into how she treats others around her.</i>
Family	Yes	No	N/A
Legal	Yes	No	N/A
Social	Yes	No	N/A
Financial	Yes	No	N/A
Other	Yes	No	N/A

Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient

Dates	Facility/MD/Therapist	Inpatient/Outpatient	Reason for Treatment	Response/Outcome
<i>Since 2020 Talks to therapist once weekly.</i>	Inpatient Outpatient Other: <i>Therapist</i>	<i>Outpatient</i>	<i>Depression that started with the pandemic/ COVID lockdown</i>	No improvement Some improvement Significant improvement
<i>Since 2020 Talks to psychiatrist once every other month.</i>	Inpatient Outpatient Other: <i>Psychiatrist</i>	<i>Outpatient</i>	<i>The patient had to see a psychiatrist to be prescribed medications.</i>	No improvement Some improvement Significant improvement
<i>N/A</i>	Inpatient	<i>N/A</i>	<i>N/A</i>	No

	Outpatient Other:			improvement
				Some improvement
				Significant improvement
Personal/Family History				
Who lives with you?	Age	Relationship	Do they use substances?	
<i>N/A Patient lives alone</i>	<i>N/A Patient lives alone</i>	<i>N/A Patient lives alone</i>	Yes	No
<i>N/A Patient lives alone</i>	<i>N/A Patient lives alone</i>	<i>N/A Patient lives alone</i>	Yes	No
<i>N/A Patient lives alone</i>	<i>N/A Patient lives alone</i>	<i>N/A Patient lives alone</i>	Yes	No
<i>N/A Patient lives alone</i>	<i>N/A Patient lives alone</i>	<i>N/A Patient lives alone</i>	Yes	No
<i>N/A Patient lives alone</i>	<i>N/A Patient lives alone</i>	<i>N/A Patient lives alone</i>	Yes	No
If yes to any substance use, explain: <i>N/A</i>				
Children (age and gender): <i>No children</i>				
Who are children with now? <i>No children</i>				
Household dysfunction, including separation/divorce/death/incarceration: <i>N/A</i>				
Current relationship problems: <i>Current relationship problems with boyfriend that have been ongoing for about a month. Boyfriend expresses he wanted to spend more time with other friends and needs space. The patient expresses she is lonely, depressed, and wants him around. He is not receptive of her wants and needs and comes off as cold and unable to love.</i>				
Number of marriages: <i>Never married</i>				
Sexual Orientation: <i>Straight</i>	Is client sexually active? Yes No		Does client practice safe sex? Yes No	
Please describe your religious values, beliefs, spirituality and/or preference: <i>"I wouldn't consider myself a Christian. I have not gone to church since high school, but I pray to God and believe in God.</i>				
Ethnic/cultural factors/traditions/current activity: <i>The client denies ethnic/cultural factors/traditions.</i>				

Describe: <i>N/A</i>
Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): <i>The client denies any current/past legal issues.</i>
How can your family/support system participate in your treatment and care? <i>“I do not believe my friend Sherry can participate in my treatment; she is very busy because she is preparing to graduate after this semester.”</i>
Client raised by: Natural parents Grandparents Adoptive parents Foster parents Other (describe):
Significant childhood issues impacting current illness: <i>Parent’s divorce (when she was 5yo) Her mother’s cold, and unloving demeanor</i>
Atmosphere of childhood home: Loving Comfortable Chaotic Abusive Supportive Other:
Self-Care: Independent Assisted Total Care
Family History of Mental Illness (diagnosis/suicide/relation/etc.) <i>Mother (undiagnosed BPD)</i>
History of Substance Use: <i>Grandfather (maternal) Previous history of alcohol abuse but has been sober since the patient can remember.</i>
Education History: Grade school High school College <i>Seeking her Bachelor of Science. Majoring in economics and Psych. She is a junior at the U of I.</i> Other:
Reading Skills:

<p>Yes No Limited</p>
<p>Primary Language: <i>Mandarin (Chinese)</i></p>
<p>Problems in school: <i>Lack of motivation Skipping lab times Dropped a class Pulling all-nighters to complete schoolwork, which negatively affects her overall mood.</i></p>
<p>Discharge</p>
<p>Client goals for treatment: <i>The client states, “I want to learn how to not think about my boyfriend leaving me. I constantly worry about what is to come or imagine living without him. I want to stop that constant worry.”</i></p>
<p>Where will client go when discharged? <i>The client will return home to her apartment complex.</i></p>

Outpatient Resources (15 points)

Resource	Rationale
<p>1. One-on-one therapy</p>	<p>1. <i>Clients may benefit from regular sessions with a licensed therapist, psychiatrist, or other mental health professional. This is an opportunity for medication changes and mental status progress or decline to be tracked. When consulting with a professional on the regular, appropriate precautions can be implemented.</i></p>
<p>2. Couple’s therapy</p>	<p>2. <i>The client may benefit by going to couple’s therapy with her partner because it encourages improvements of communication skills between them both. Couple’s therapy helps one discover the root causes of the major conflicts and created better understanding between the two parties.</i></p>
<p>3. Relationship struggle support group</p>	<p>3. <i>Relationship support groups can help people feel lonely, isolated, and criticized in their relationships. The patient does not have many friendships and easily feels neglected or alone; a support group could encourage her to talk openly and honestly about her feelings with an unbiased crowd.</i></p>

Current Medications (10 points)
Complete all of your client's psychiatric medications

Brand/Generic	<i>Oxcarbazepine (Trileptal)</i>	<i>Benztropine (Cogentin)</i>	<i>Haloperidol (Haldol)</i>	<i>N/ A</i>	<i>N/ A</i>
Dose	<i>150mg</i>	<i>2mg</i>	<i>5mg</i>	<i>N/ A</i>	<i>N/ A</i>
Frequency	<i>BID</i>	<i>BID</i>	<i>Every 4 hours PRN</i>	<i>N/ A</i>	<i>N/ A</i>
Route	<i>Oral</i>	<i>Oral</i>	<i>Oral</i>	<i>N/ A</i>	<i>N/ A</i>
Classification	<i>P: Carboxamide derivative T: Anticonvulsant</i>	<i>P: Anticholinergic T: Antiparkinsonian, central acting anticholinergic</i>	<i>P: Butyrophenone derivative T: Antipsychotic</i>	<i>N/ A</i>	<i>N/ A</i>
Mechanism of Action	<i>May prevent or halt seizures by blocking or closing sodium Channels in neuronal cell membrane</i>	<i>Blocks acetylcholine's action of cholinergic receptor sites.</i>	<i>May block postsynaptic dopamine receptors in the limbic system and increase brain turnover of dopamine, producing an antipsychotic effect.</i>	<i>N/ A</i>	<i>N/ A</i>
Therapeutic Uses	<i>An adjunct to treat partial seizures</i>	<i>To treat acute dystonic reactions</i>	<i>To treat psychosis and schizophrenia</i>	<i>N/ A</i>	<i>N/ A</i>
Therapeutic Range (if applicable)	<i>N/A</i>	<i>N/A</i>	<i>N/A</i>	<i>N/ A</i>	<i>N/ A</i>
Reason Client Taking	<i>This is sometimes prescribed for someone with bipolar disorder</i>	<i>To treat involuntary movements such as tremors or stiffness.</i>	<i>Psychotic episodes</i>	<i>N/ A</i>	<i>N/ A</i>
Contraindication	<i>Hypersensitivit</i>	<i>1) urinary retention</i>	<i>Dementia with</i>	<i>N/ A</i>	<i>N/ A</i>

s (2)	<i>y to oxcarbazepine, eslicarbazepine acetate, or their components</i>	<i>2) Myasthenia Gravis and Autonomic neuropathy</i>	<i>Lewy bodies, hypersensitivity to haloperidol or its components.</i>	<i>A</i>	<i>A</i>
Side Effects/Adverse Reactions (2)	<i>1) Dizziness 2) Somnolence</i>	<i>1) Hypotension 2) Blurred vision</i>	<i>1)Hypothermia 2) Cardiac arrest</i>	<i>N/A</i>	<i>N/A</i>
Medication/Food Interactions	<i>Hormonal contraceptives, phenytoin, strong CYP3A4 or UGT inducers</i>	<i>Clozapine Glucagon Glycopyrrolate Glycopyrronium Tosylate Methacholine Metoclopramide Quetiapine Revefenacin Scopola</i>	<i>Anticholinergics , rifampin, CNS depressants</i>	<i>N/A</i>	<i>N/A</i>
Nursing Considerations (2)	<i>1) Know that patient with allergic reaction to carbamazepine may have hypersensitivity to oxcarbazepine.</i>	<i>1) expect to administer I.V or I.M when patient needs more rapid response than oral drug can provide 2) Usually start off as a low dose and rapidly increases over time</i>	<i>1) Should not be used to treat dementia-related psychosis 2) Use cautiously in patients with a history of prolonged QT interval.</i>	<i>N/A</i>	

Brand/Generic	<i>N/A</i>	<i>N/A</i>	<i>N/A</i>	<i>N/A</i>	<i>N/A</i>
Dose	<i>N/A</i>	<i>N/A</i>	<i>N/A</i>	<i>N/A</i>	<i>N/A</i>
Frequency	<i>N/A</i>	<i>N/A</i>	<i>N/A</i>	<i>N/A</i>	<i>N/A</i>
Route	<i>N/A</i>	<i>N/A</i>	<i>N/A</i>	<i>N/A</i>	<i>N/A</i>
Classification	<i>N/A</i>	<i>N/A</i>	<i>N/A</i>	<i>N/A</i>	<i>N/A</i>
Mechanism of	<i>N/A</i>	<i>N/A</i>	<i>N/A</i>	<i>N/A</i>	<i>N/A</i>

Action					
Therapeutic Uses	N/A	N/A	N/A	N/A	N/A
Therapeutic Range (if applicable)	N/A	N/A	N/A	N/A	N/A
Reason Client Taking	N/A	N/A	N/A	N/A	N/A
Contraindications (2)	N/A	N/A	N/A	N/A	N/A
Side Effects/Adverse Reactions (2)	N/A	N/A	N/A	N/A	N/A
Medication/Food Interactions	N/A	N/A	N/A	N/A	N/A
Nursing Considerations (2)	N/A	N/A	N/A	N/A	N/A

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2021). *2021 Nurse's Drug Handbook* (20th ed.). Jones & Bartlett Learning

Mental Status Exam Findings (20 points)

<p>APPEARANCE: Behavior: Cooperative, Engaged, Calm Build: Endomorph Attitude: Positive, open Speech: Appropriate for age, clear Interpersonal style: Relator Mood: Down, happy to talk with me Affect: Calm</p>	<p><i>The client is a 20-year-old female. She is groomed and dressed comfortably in her own clothes. The client was calm, engaged, and extremely open to being interviewed. Her eye is strong, and she appeared to be consciously present. The client's speech was clear and concise. The client was happy to partake in the conversation.</i></p>
<p>MAIN THOUGHT CONTENT: Ideations: None Delusions: None Illusions: None Obsessions: None Compulsions: None Phobias: None</p>	<p><i>At the time of assessment (04.19.22), the client did not appear to be experiencing any suicidal ideations, delusions or illusions, or obsessive compulsions. The client did not state any phobias that they might have.</i></p>
<p>ORIENTATION: Sensorium: Conscious Thought Content: Realistic, and coherent</p>	<p><i>The client is alert and oriented x4 (person, place, time, situation). The client does not appear to be in any acute distress. Rational thought process</i></p>
<p>MEMORY: Remote: WNL</p>	<p><i>The client's memory is intact and can recall past events during the conversation.</i></p>
<p>REASONING: Judgment: WNL Calculations: WNL Intelligence: WNL Abstraction: WNL</p>	<p><i>The client's reasoning is intact. The client understands why they are at the facility and has accepted their diagnosis and treatment options. The client can specify the processes involved in completing treatment as well as their long-term</i></p>

Impulse Control: <i>WNL</i>	<i>objectives.</i>
INSIGHT: <i>Good</i>	<i>The client understands and accepts their diagnosis of BPD. She understands she is experiencing depression and accepts the fact that she needs help.</i>
GAIT: Assistive Devices: <i>None</i> Posture: <i>WNL</i> Muscle Tone: <i>WNL</i> Strength: <i>WNL</i> Motor Movements: <i>WNL</i>	<i>The client shows no muscular atrophy in limbs. The client does not need any assistive devices and has great posture. Muscle tone and strength appear to be strong, and the client has no difficulty with motor movements.</i>

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
<i>1400</i>	<i>64</i>	<i>111/66</i>	<i>16</i>	<i>98.3</i>	<i>98</i>
<i>1600</i>	<i>68</i>	<i>118/70</i>	<i>18</i>	<i>98.3</i>	<i>99</i>

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
<i>Admission</i>	<i>0</i>	<i>N/A</i>	<i>N/A</i>	<i>N/A</i>	<i>N/A</i>

1700	0	N/A	N/A	N/A	N/A
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Dietary Data (2 points)

Dietary Intake	
<p>Percentage of Meal Consumed:</p> <p>Breakfast: 90%</p> <p>Lunch: 80%</p> <p>Dinner: N/A Was not finished with dinner at the time of interview.</p>	<p>Oral Fluid Intake with Meals (in mL)</p> <p>Breakfast: 480 mL (OJ & grape juice)</p> <p>Lunch: 480 mL (OJ & grape juice)</p> <p>Dinner: N/A Was not finished with dinner at the time of interview.</p>

Discharge Planning (4 points)

Discharge Plans (Yours for the client): *The client will be discharged to her apartment complex where she lives alone. No safety equipment or home health care needs are needed for this client. Prior to admission, the client has been seeing an outpatient therapist she talks to once weekly. She will follow up with her therapist after her discharge. I will educate the patient on the potentially harmful effects of taking over the prescribed amount of medications. The client will be given informational materials on additional outpatient resources she can seek help from including but not limited to, group therapy, individual psychotherapy, and couple’s therapy.*

Nursing Diagnosis (15 points)

Must be NANDA approved nursing diagnosis and listed in order of priority

<p>Nursing Diagnosis</p> <ul style="list-style-type: none"> • Include full nursing diagnosis with “related to” and “as evidenced by” components 	<p>Rational</p> <ul style="list-style-type: none"> • Explain why the nursing diagnosis was chosen 	<p>Immediate Interventions (At admission)</p>	<p>Intermediate Interventions (During hospitalization)</p>	<p>Community Interventions (Prior to discharge)</p>
<p>1. <i>Self-directed violence related to the client’s depression as evidenced by the suicide gesture.</i></p>	<p><i>The client states she did not present to the ED with a suicide attempt, but a suicide gesture is still an act of self-harm and is pertinent to be addressed.</i></p>	<p>1. <i>Identify the client’s psycho status</i> 2. <i>Ask the client, “Have you thought about killing yourself? If she responds yes, ask if he/she has a plan.</i> 3. <i>Remove items from the client’s personal items that may be used to harm themselves.</i></p>	<p>1. <i>Convey a nonjudgmental attitude when talking with the client</i> 2. <i>Be attentive and actively listen while client speaks. Do not challenge the client’s statements.</i> 3. <i>Avoid comparing the client with others.</i></p>	<p>1. <i>Assist the customer in locating local resources.</i> 2. <i>Provide crisis prevention center phone numbers to the client and family members. Suicide prevention help lines, counselors, and other local resources are available.</i> 3. <i>Encourage the person to make collaborating with psychiatric intervention a goal.</i></p>
<p>2. <i>Anxiety related to current breakup as evidenced by complaints of tremors and elevated heart rate.</i></p>	<p><i>The client’s anxiety is pertinent as it can affect other aspects of her life such as schooling.</i></p>	<p>1. <i>Ask the client what triggers her anxiety</i> 2. <i>Grab the patient’s medication history</i> 3. <i>Discuss the patient’s coping and problem-solving</i></p>	<p>1. <i>Listen attentively, allow patient to express feelings verbally</i> 2. <i>Include patient in decisions related to care, when feasible</i> 3. <i>Accept patient as is.</i></p>	<p>1. <i>Refer patient to community or professional mental health resources to provide ongoing mental health assistance.</i> 2. <i>Allow extra visiting periods with family and friends if this seems to allay patient’s anxiety</i></p>

		<i>ability</i>		<i>3.Help patient develop own techniques for dealing with fears to establish alternatives to escape or avoidance behaviors.</i>
<i>3. Imbalanced nutrition: more than body requirements related to overeating as evidenced by client seeking food for comfort.</i>	<i>The client is at an increased risk for health issues developing if she continues finding comfort in overeating.</i>	<ol style="list-style-type: none"> <i>1. Ask the client to review their regular eating patterns throughout the day.</i> <i>2. Weight the client to have a baseline to compare it to.</i> <i>3. Provide nutritional meals that are lower in carbs.</i> 	<ol style="list-style-type: none"> <i>1. Monitor Is and Os</i> <i>2. Set a weight loss if the weight has gotten out of control.</i> <i>3. Provide inviting opportunities for the client to discuss reasons or triggers as to why she is overeating.</i> 	<ol style="list-style-type: none"> <i>1. Involve client’s family or support system in meal planning</i> <i>2. Refer client to dietician.</i> <i>3. Speak with a case manager in the instance that the patient does not have money for a healthy diet.</i>

Other References (APA):

Concept Map (20 Points):

Subjective Data

Nursing Diagnosis/Outcomes

Nursing Diagnosis

- Self-directed violence related to the client's depression as evidenced by the suicide gesture.
- Anxiety related to current breakup as evidenced by complaints of tremors and elevated heart rate.
- Imbalanced nutrition: more than body requirements related to overeating as evidenced by client seeking food for comfort.

"I am feeling down."

"My ER experience was scary, they treated me awful."

Outcomes

- The client will attend therapy session with a mental health profession
- Patient will experience reduced anxiety by identifying precipitating situations
- The client continues to eat a healthy, balanced diet.

Objective Data

Patient Information

Nursing Interventions

1. Convey a nonjudgmental attitude when talking with the client
 2. Be attentive and actively listen while client speaks. Do not challenge the client's statements.
 3. Avoid comparing the client with others
- Pulse: 64
 BP: 111/66
 RR: 16
 Temperature: 98.6
 Oxygen on Room air: 98%
1. Listen attentively, allow patient to express feelings verbally
 2. Include patient in decisions related to care and health planning with relationships and feelings of abandonment.
 3. Accept patient as is.
1. Monitor Is and Os
 2. Set a weight loss if the weight has gotten out of control.
 3. Provide inviting opportunities for the client to discuss reasons or triggers as to why she is overeating

Jennifer is a 20yo female who was admitted from Carle ER. She presented to Carle ER 4/15 after a suicide gesture. She reports she took a handful of mirtazapine 15mg to get her boyfriend's attention. The patient has BPD and admits to having a difficult time dealing with relationships and feelings of abandonment.

